

2018 Medicare Advantage PFFS in Erie County

TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	Universal American 1-866-422-1967							
		Todays Options Premier 300 No RX		Todays Options Premier 200 No RX		Todays Options Premier Plus 650B		Todays Options Premier Plus 250A	
PREMIUMS	\$134	\$0		\$62		\$24		\$123	
Deductible	\$183	\$0		\$0		\$0		\$0	
		In	Out	In	Out	In	Out	In	Out
PCP Visits	20%**	\$5	\$15	\$0	\$10	\$10	\$25	\$0	\$10
Wellness Exam	\$0	\$0	\$15	\$0	\$10	\$0	\$25	\$0	\$10
Specialty Visits	20%**	\$30	\$50	\$25	\$35	\$35	\$60	\$25	\$35
Outpatient Mental Health	20%	\$40	30%	\$30	30%	\$40	30%	\$30	30%
Outpatient Substance Abuse	20%**	\$40	30%	\$30	30%	\$40	30%	\$30	30%
Outpatient Surgery	20% **	\$200/\$250	30%	\$150/\$200	30%	\$250/\$300	30%	\$250/\$300	30%
Emergency Care	20% **	\$80; 20% World Wide Coverage		\$100; 20% World Wide Coverage		\$80; 20% World Wide Coverage		\$100, 20% worldwide coverage	
Urgent Care	20% **	\$35		\$35		\$35		\$35	
Ambulance Services	20% **	\$300		\$300		\$300		\$300	
Durable Medical Equipment	20% ** (must use Medicare supplier)	20%	30%	20%	30%	20%	30%	20%	30%
Prosthetic Devices	20% **	20%	30%	20%	30%	20%	30%	20%	30%
X Rays	20% **	\$15	30%	\$15	30%	\$15	30%	\$15	30%
Lab Services	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Radiation Therapy	20%	20%	30%	20%	30%	20%	30%	20%	30%
Diagnostic Radiology	20%	20%	30%	20%	30%	20%	30%	20%	30%
Chiropractic Care	20% limited coverage	\$20	30%	\$20	30%	\$20	30%	\$20	30%
Medically Necessary Foot Care	20% limited coverage	\$45 Certain conditions only	30% Certain conditions only	\$35 Certain conditions only	30% Certain conditions only	\$50 Certain conditions only	30% Certain conditions only	\$35 Certain conditions only	30% Certain conditions only
Routine Foot Care	NOT COVERED	*Restrictions May Apply		*Restrictions May Apply		*Restrictions May Apply		*Restrictions May Apply	
P.T.,O.T. and Speech Therapy	20% **	\$35	30%	\$15	30%	\$40	30%	\$15	30%
Cardiac Rehab	20%	\$35	30%	\$15	30%	\$40	30%	\$15	30%
Dialysis	20%	20%	30%	20%	30%	20%	30%	20%	30%

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		In	Out	In	Out	In	Out	In	Out
Inpatient Hospital	\$1,340	\$260/day days 1-6, \$0/day days 7+	\$300/day days 1-7, \$0/day days 8+	\$500 per stay	\$300/day days 1-7, \$0/day days 8+	\$295/day days 1-5, \$0/day days 6+	\$300/day days 1-7, \$0/day days 8+	\$500 per stay	\$300/day days 1-7, \$0/day days 8+
Inpatient Mental Health*	\$1,340	\$260/day days 1-6, \$0/day days 7+	\$300/day days 1-7, \$0/day days 8+	\$500 Per Stay	\$300/day days 1-7, \$0/day days 8+	\$295/day days 1-5, \$0/day days 6+	\$300/day days 1-7, \$0/day days 8+	\$500 Per Stay	\$300/day days 1-7, \$0/day days 8+
Skilled Nursing Facility	\$0 day days 1-20 \$167.50/day days 21-100	\$0 day days 1-20; \$165 day days 21-100	\$0 day days 1-20; \$250 day days 21-100	\$0 day days 1-20; \$150 day days 21-100	\$0 day days 1-20; \$200 day days 21-100	\$0 day days 1-20; \$165 day days 21-100	\$0 day days 1-20; \$250 day days 21-100	\$0 day days 1-20; \$150 day days 21-100	\$0 day days 1-20; \$200 day days 21-100
Home Health Care	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Mammograms	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Bone Mass Measurement	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Colorectal Screening Exams	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Flu, Pneumonia & Hepatitis B	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Prescription Drugs	20% Part B covered only NO PART D	No RX 20% Part B Only	No RX 30% Part B Only	No RX 20% Part B Only	No RX 30% Part B Only	(Preferred) Copays \$2/\$7/\$37/\$90/33% No Deductible 20% Part B	(Standard) Copays \$7/\$14/\$47/\$100/ 33% No Deductible 30% Part B	Copays \$0/\$5/\$35/\$75/33% No Deductible 20% Part B	Copays \$0/\$5/\$35/\$75/33% No Deductible 30% Part B
Vision services	20% + 1 pair glasses/frames/contact after cateract surgery 20% + retinopathy exam 1/x yr for diabetics	\$0 In Network Exams & Screenings, 30% Out of Network Exams & Screenings \$20 In Network Post Cataract Eyewear, 30% Out of Network Post Cataract Eyewear							
Hearing Services	20%	\$20 In Network: Exams & Screenings 30% Out of Network: Exams & Screenings							
Diabetic training and supplies	20%	\$0-20%	30%	\$0-20%	30%	\$0-20%	30%	\$0-20%	30%
Dental Coverage	limited coverage	\$30 Medicare Covered Only	\$50 Medicare Covered Only	\$25 Medicare Covered Only	\$35 Medicare Covered Only	\$35 Medicare Covered Only	\$60 Medicare Covered Only	\$25 Medicare Covered Only	\$35 Medicare Covered Only
Max out of Pocket		\$6,700		\$3,400		\$6,700		\$3,400	
Full LIS		No RX		No RX					
Full LIS & EPIC		No RX		No RX					